

## **1.0 Definition of the Procedure**

Biventricular pacing is a technique used to coordinate the contraction of the ventricles, thus improving the hemodynamic status of the patient with congestive heart failure (CHF). Cardiac resynchronization therapy (CRT) with biventricular pacing improves both hemodynamic and clinical performance of patients with CHF. Biventricular pacemakers use three leads, one in the right atrium, and one in each ventricle.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid eligible individuals with a need for this specialized treatment confirmed by a licensed physician are eligible as long as they meet individual eligibility requirements. Medicaid recipients may have service restrictions due to their eligibility category, which would make them ineligible for this service.

### **2.2 Special Provisions**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at <http://www.dhhs.state.nc.us/dma/prov.htm>.

## **3.0 When the Procedure is Covered**

Each recipient's condition is evaluated on an individual basis. There may be other conditions that are indications for coverage.

The N.C. Medicaid program covers biventricular pacemakers as a treatment for congestive heart failure in patients who meet the following criteria:

1. NYHA Class III or IV
2. left ventricular ejection fraction less than 35%
3. QRS duration of greater than or equal to 150msec.
4. treatment with one or more of the following pharmacological/medical regimes prior to implant:
  - a. beta-blocker or angiotensin receptor blocker
  - b. ace inhibitor or angiotensin receptor blocker
  - c. digoxin
  - d. diuretics

## **4.0 When the Procedure is Not Covered**

Biventricular pacemakers as a treatment for congestive heart failure is not covered when the medical necessity criteria listed in **Section 3.0** are not met. Each recipient's condition is evaluated on an individual basis. There may be other conditions that are indications for non-coverage.

The N.C. Medicaid program does not cover biventricular pacemakers for patients whose heart failures or ventricular arrhythmias are reversible or temporary.

### **4.1 History of or Active Substance Abuse**

Must have documentation of substance abuse program completion plus six months of negative sequential random drug screens.

**Note:** To satisfy the requirement for sequential testing as designated in this policy, the Division of Medical Assistance (DMA) must receive a series of test (alcohol and drug) results spanning a minimum six-month period, allowing no fewer than a three-week interval and no more than six-week interval between each test during the given time period. A complete clinical packet for prior approval must include at least one documented test performed within one month of the date of request to be considered.

### **4.2 Psychosocial History**

Psychosocial history that would limit ability to comply with medical care pre and post transplant.

### **4.3 Medical Compliance**

Current patient and/or caretaker non-compliance that would make compliance with a disciplined medical regime improbable.

## **5.0 Requirements for and Limitations on Coverage**

All applicable N.C. Medicaid policies and procedures must be followed in addition to the ones listed in this procedure.

All biventricular pacemakers must be prior approved by DMA.

## **6.0 Providers Eligible to Bill for the Procedure**

Physicians enrolled in the N.C. Medicaid program who perform this procedure may bill for this service.

## **7.0 Additional Requirements**

FDA approved procedures, products, and devices must be utilized for implantation.

Implants, products, and devices must be used in accordance with the applicable FDA requirements current at the time of the procedure.

A statement signed by the surgeon certifying all FDA requirements for the implants, products, and devices must be retained in the recipient's medical record and made available for review upon request.

## **8.0 Policy Implementation/Revision Information**

**Original Effective Date:** January 1, 1994

### **Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
7/1/05	Entire Policy	Policy was updated to include coverage criteria effective with approved date of State Plan amendment 4/1/05.
9/1/05	Section 2.2	The special provision related to EPSDT was revised.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.

## Attachment A

### Claims Related Information

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in the Medicaid Managed Care programs.

**A. Claim Type**

1. Physicians bill professional services on the CMS-1500 claim form.
2. Hospitals bill for services on the UB-92 claim form.

**B. Diagnosis Codes**

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

**C. Procedure Codes**

Covered biventricular pacemaker codes include:

33213	33224	33225	33226
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**D. Providers must bill their usual and customary charges.**